MARYLAND
Department of Health

Client Services
500 N. Calvert St., 5th Fl., Baltimore, MD 21202
Phone: (410) 767-6535 or Toll Free: 1-800-205-6308
or TTY- Maryland Relay Service 1-800-735-2258
Fax Numbers: (410) 333-2608; (410) 244-8696; (410) 244-8617

A-3: Cash Only Verification Form

MADAP ID: 94-_____

This form must be completed and signed by any applicant who does not receive paystubs. Complete all applicable questions below to support your household income eligibility for assistance. Return this form with the application.

If you are self-employed fill in sections 1 and 2 only.

Section 1:

First Name: _____ MI: _____ Last Name: _____ Suffix: _____

Date of Birth: _____/____/____ Social Security Number: _____-_____-_____

Section 2:

List the last four (4) consecutive pay amounts paid:

Pay Date:	Gross Pay:	Tips:	Totals:
_____	$_____	$_____	$_____
_____	$_____	$_____	$_____
_____	$_____	$_____	$_____
_____	$_____	$_____	$_____
Totals:	$_____	$_____	$_____

Section 3:

1. Pay rate is: $ _____ per hour.
2. Number of hours worked per week: _____
3. Frequency of pay: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other: _____
4. Are you a seasonal worker? ☐ No ☐ Yes, and my work schedule is: _____

I certify that the information provided on this form and any attached documentation is true, correct and complete.

Applicant's Signature: _____ Date: _____